ILLINOIS DEPARTMENT OF Healthcare and Family Services

Prior Authorization Request Form
Risperdal Consta (risperidone long-acting injection)

Identification Information

Patient Information (required):

Name:_____

DOB:_____

Nine-Digit IDHFS ID Number:_____

LTC Facility Information (if applicable):

Facility Name:_____

Phone:_____

Fax:_____

Physician Information (required):

Name:_____

Phone:_____

Fax:_____

State License #:_____

Pharmacy Information (if available):

Pharmacy Name:_____

Phone:_____

Fax:_____

HFS Provider #:_____

Clinical Information

All approved requests will be subject to quantity limits

Medication: **Risperdal Consta** Strength:_____ Quantity:_____ Refills:_____

Directions for use:_____

- ☐ Patient initiating therapy with Risperdal Consta
- ☐ Patient continuing therapy with Risperdal Consta

**If initiating therapy at a dose other than 25mg, please provide justification below:

_____

1. Prescribing physician is a psychiatrist? ☐ Yes ☐ No If no, please indicate specialty_____
2. Diagnosis is schizophrenia? ☐ Yes ☐ No If no, please specify_____
3. Reason for prescribing Risperdal Consta:
   - ☐ Nonadherence to oral antipsychotics
   - ☐ Other (please explain)_____
4. Patient has had previous exposure to risperidone? ☐ Yes ☐ No
5. Intention to begin tapering off oral antipsychotics after 3 weeks? ☐ Yes ☐ No

If no, please explain:_____

Additional Information:_____

_____

Please complete form and fax to 217-524-7264
To request prior authorization by phone call 1-800-252-8942